Beyond the Symptoms:

Generalizations and Distinctions between Eating Disorders with Different Symptom Manifestations in Psychoanalysis

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Abstract

In an investigation of eating disorders from an object relations and self psychological perspective, which originally began as a personal inquiry into bulimia, the psychoanalytic framework for anorexia and bulimia is examined. Although these theories tend to generalize all disturbed relationships with food as "eating disorders" and discuss the category as a whole, considering the differences between anorexia and bulimia, in symptom manifestation, causation, and treatment, provides a more complete understanding of the eating disordered patient in her psychic structure and relationship with reality, the external world, and others. Ultimately, these differences complicate the approach to psychoanalytic treatment, but recognition of where anorexic and bulimic patients diverge may imbue the therapeutic space with new hope.

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The human relationship to food is undeniably elaborate. According to Hilde Bruch (1973), author of the seminal work on anorexia nervosa, “there is no human society that deals rationally with food in its environment, that eats according to the availability, edibility, and nutritional value alone. Food is endowed with complex values and elaborate ideologies, religious beliefs, and prestige systems” (p. 3). Not only does food play a prominent role in culture and society, it also serves as the first bridge between baby and caretaker, characterizing every person’s earliest interactions with the world. In psychoanalysis, the quality of this first baby-caretaker interaction is understood to determine the baby’s self-maturation and, by extension, the character of her relationship with reality and with others. Thus, food, the feeding process, and relationships between people are all connected from the earliest stages of life.

With food caught in a matrix of physical, psychical, and cultural significance, it is no wonder that eating disorders pose an enormous challenge for psychoanalysts. Caparrotta and Ghaffari (2006) propose, “eating disorders occupy an interesting place at the interface between body and mind, emotions and cognition, childhood and adulthood and most of all between the individual, the family, and society at large” (p. 191). This position is difficult to navigate and has been explored in depth by object relations theorists and self psychologists who have encountered challenging cases in eating disordered patients.

Object relations and self psychological perspectives have lent great insight into the inner workings of the eating disordered patient by establishing a framework for child development reliant on an empathically attuned relationship between caretaker and infant. Disturbances in this relationship can result in eating disorders due to the particular location of food as a nourishing connection between mother and baby. However, these theories tend to generalize all disturbed relationships with food as "eating disorders" and discuss the category as a whole. Indeed, some theorists haven't explicitly discussed eating disorders (Klein, 1973), some have discussed only one type briefly (Winnicott, 1971) or more in depth (Bruch, 1973), and others have discussed the category generally without getting into specifics. The disorders, anorexia nervosa and bulimia nervosa, are rarely distinguished from each other beyond discussion of particular symptom manifestations.

In my own experience, as a recovering bulimic and a student of psychoanalysis, I have felt profoundly disturbed not only by the lack of distinction between the disorders but also by my own burning desire to be structured like the anorectic rather than the bulimic I am, my envy of those who have the "virtue," if you will, to slowly waste into nothingness, and my complete inability to be one of them. Exploration into the configuration of my own disorder has lead me to question why I suffer this particular disorder rather than another, and in a broader sense, why any eating disordered individual is structured in the distinct fashion in which their symptoms present.

The symptom manifestations of anorexia and bulimia differ dramatically; anorexia presents as severe caloric restriction whereas bulimia appears as cyclical binging and purging. It stands to reason that there is some constitutional difference

between the two disorders, which is embodied by their differing symptomatology. I propose that by exploring where these two disorders converge and diverge from a self-psychological and object relations standpoint, psychoanalysis may be able to shed light on the root of disordered eating and clarify fundamental differences between anorectics and bulimics, leading to an understanding of the most effective course of treatment in each case. The previous endeavors into eating disorders from object relations and self psychological perspectives, based largely on the work of Klein, Winnicott, and Kohut, although generalized, serve as an infrastructure from which to begin comparing anorexia and bulimia.

Object Relations Theory

Studies of eating disorders from an object-relations perspective commonly find that some disturbance in the mother-infant relationship has curtailed ego development between two early and essential positions in development originally named by Melanie Klein: the paranoid-schizoid position and the depressive position (Segal, 1973). In the paranoid-schizoid position, the infant is completely dependent on her first object, the mother or primary caregiver. Due to her responsiveness to the infant's needs, the mother is initially perceived as being a part of the baby's internal world and is recognized as a part-object, the breast. Klein works with Freud's drive theory, believing that "the immature ego of the infant is exposed from birth to the anxiety stirred up by the inborn polarity of instincts – the immediate conflict between the life instinct and the death instinct" (Segal, 1973, p. 25). The ego projects these instincts outwards into the original object, and the object is therefore felt as two parts: the ideal breast and the persecutory one. By providing love, comfort, and food, the mother is perceived as an "ideal breast"

which is seen as “life-giving and protective” (Segal, 1973, p. 26). In her absence, causing discomfort and frustration, the mother is perceived as a “persecutory breast” (Segal, 1973, Ch. 3).

A primary defense mechanism in the paranoid-schizoid position is projective identification, in which “the subject in phantasy projects large parts of himself into the object, and the object becomes identified with the parts of the self that it is felt to contain” (Segal, 1957, p. 393) The process of symbol formation begins with the first projective identifications. However, the earliest symbols are not felt by the ego as substitutes for the object, but rather as the original object itself. Segal (1957) termed this phenomenon “symbolic equation.” Because the differentiation between self and object is confused in the paranoid-schizoid position, “the symbol – which is a creation and function of the ego – becomes, in turn, confused with the object that is symbolized” (Segal, 1957, p. 393). Experience in the paranoid-schizoid position is therefore characterized by concrete thinking.

Ultimately, in a well-attuned and responsive mother-infant relationship, the baby’s positive connection with the ideal breast will begin to outweigh the fear of the bad breast and the baby’s ego will mature into the depressive position, where the mother is recognized as a whole object that is at times, good, bad, present, or absent. This realization necessitates the integration of the infant’s ego; once mother is a whole object that can be both good and bad, the infant relates herself to that object and recognizes that her own ego is whole and not split into good and bad (Segal, 1973, Ch. 6). Furthermore, an increasing awareness and differentiation between the ego and the object facilitates the formation of true symbols, fostering a move away from symbolic equivalence. Segal

(1957) asserts that “the symbol here is not an equivalent of the original object, since the aim of the displacement is to save the object, and the guilt experienced in relation to it is far less than that due to an attack on the original object” (p. 394). Symbolization develops in parallel with the infant’s progression through the paranoid-schizoid and depressive positions, allowing growth and change in the ego’s object relations.

Based on this developmental progression, the breakdown of the mother-infant unit creates an unstable environment where the infant is unable to comprehend a definitive awareness of what is inside and outside the body (Kadish, 2012). Without fully progressing through the depressive position, the eating disordered individual is left with a chaotic, confused sense of what is “me” and what is “not me,” what belongs to external reality versus the internal landscape. Her behavior towards food reflects her inner chaos.

In some ways, eating disordered individuals use their food relationship to relieve the strain of relating inner and outer reality. The disordered patient’s disturbed behaviors around eating, Ferguson and Mendelsohn (2011) argue, function as transitional objects, a term used by Winnicott (1971) to describe items used by children in the progression from the paranoid-schizoid position to the depressive position. In a healthy, well-attuned parent-child relationship, the transitional object (commonly a soft toy or blanket) occupies an intermediate area of experience, between oral erotism and the true object relationship, between the baby’s inability and growing ability to recognize and accept reality. The transitional object is essential to the development of the ability to symbolize, as Winnicott explains, “I think there is use for a term for the root of symbolism in time, a term that describes the infant’s journey from the purely subjective to objectivity; and it

seems to me that the transitional object (piece of blanket, etc.) is what we see of this journey of progress towards experiencing" (p. 6).

Nevertheless, one can fail in the creation of a transitional object. The object itself is not transitional; rather it represents "the infant's transition from a state of being merged with the mother to a state of being in relation to the mother as something outside and separate" (Winnicott, 1971, p. 14 – 15). In an insecure environment where separation from the mother is sudden or otherwise traumatic, the function of the transitional object can be perverted to deny separation. Winnicott (1971) examines a case of a young boy who experienced early and repeated separations from his depressive mother and subsequently developed an obsession with everything having to do with string, joining together common household objects and furniture with it and once tying a string around his baby sister's neck. Winnicott explains the boy's behavior as a "way of dealing with a fear of separation, attempting to deny separation by his use of string, as one would deny separation from a friend by using the telephone" (p. 17). The string boy's transitional object became a fetish due to trauma in the development of the relation to mother as object.

Individuals with eating disorders are very similar to the string boy in that they have not experienced adequate attuned responsiveness to their needs in order to facilitate symbolization, and have not been able to make meaning out of their experiences of desire. These people generally sense that pursuing satisfaction may have destructive consequences. Their symptoms, self-starvation or other self-negating behaviors such as binging and purging, serve to manage hunger, the most basic desire, allowing for some sense of agency and control in the face of the overwhelming need for satiation (Ferguson

& Mendelsohn, 2011). Ferguson and Mendelsohn (2011) explain that these behaviors function as Winnicott's transitional phenomena by preserving "a precious, yet fragile, 'tendril' of the patient's original, developmental omnipotence" (p. 359) and existing in a "transitional space between the patient's concrete and symbolic modes of representation and self-expression" (p. 360). Like a teddy bear, eating disorder symptoms can be magical and precious to the patient, existing in a safe and sacred space. But these symptoms serve to deny and resist healthy separation and object relations, existing as perverted forms of transitional objects.

In contrast to Ferguson and Mendelsohn's (2011) position that eating disorders can occupy the transitional space, Kadish (2012) draws a distinction between transitional objects and intermediate objects, asserting that eating disorders fall into the latter category. The intermediate object serves as a forerunner to transitional objects, acting as an additional stage in the progression from the use of the body to the use of the transitional object. This idea echoes Bollas (1979), who posits the transformational object, "the experience of an object that transforms the subject's internal and external world," as a precursor to the transitional object (p. 104). Because total dependence characterizes the infant's earliest relationship with the mother, "there is an extremely active network of exchange between mother and child, a constant process of negotiated moments that cohere around the rituals of psychosomatic needs: i.e. feeding, diapering, sleeping, holding" (Bollas, 1979, p. 97). This transformational process of internal and external gratifications serves as the infant's first object. While Kadish has a concept of an intermediate object as a concrete external object rather than the transformational "process as object," his claim that the intermediate object must originate from the body, such as

milk, and as such typically functions as a bridge from infant to mother, concurs with the concept of a transformational process. The intermediate object is used in the transformational process to meet an infant's psychosomatic needs. These objects are perceived as joint possessions belonging to mother and infant, hence diminish in value when they are detached from the body, whereas transitional objects have robustness and sustained existence between "me" and "not me." Eating disordered patients, according to Kadish (2012), use food and bodily products (e.g. vomit) as if they *are* the object in order to deny and substitute for the object. They exist in concrete states of thinking where there is no possibility of symbolization, only symbolic equivalence. Therefore, their symptoms must serve as intermediate objects, rather than transitional objects, as that would require some awareness of the separation between self and object.

Self Psychology

Kohut, the father of self-psychology, has a concept of child development that does not deviate greatly from that of Klein or Winnicott, although he specifically emphasizes the infant's need for empathic mirroring and idealization in the maternal response in order to develop a healthy sense of self. In self psychology, the main caretaker, experienced as part of the self, is not an object but a *self*object, which exists as the provider of psychological functions and is not experienced as a true distinct object (Siegel, 1996). The parent serves critical selfobject functions by responding *empathically* to the child, making the child feel understood in a core, fundamental way. Through empathic relationships, the self develops out of a state of primary narcissism, which has qualities similar to the paranoid-schizoid position of Klein's object relations theory (Siegel, 1996). Primary narcissism is inevitably upset by the failure of the caretaker's

ministrations, but “the baby’s psychic organization…attempts to deal with the disturbances by the building up of new systems of perfection” (Kohut, 1966, p. 100). By this process, two streams of maturing narcissism develop simultaneously into the configurations of the narcissistic self and the idealized parental imago.

The development and configuration of the idealized parental imago is particularly important for understanding eating disorder symptoms. The idealized parental imago evolves from primary narcissism as the infant attempts to restore a disrupted state of blissful perfection by “imbuing the rudimentary you, the adult, with absolute perfection and power” (Kohut, 1966, p. 100). The child lets all power reside with the idealized object and seeks a constant union with it in an effort to feel whole and alive. Psychic structure develops as these idealizations are gradually withdrawn from the child’s caretakers by a process of “transmuting internalization” (Segal, 1996, Ch. 5). It is explained that, “during an important transitional period when gratification and frustration are gradually recognized as coming from an external source, the object alternatingly emerges from and resubmerges into the self” (Kohut, 1966, p. 101). Finally, the lost ideal object is “withdrawn and internalized in the form of an unconscious memory. The lost object is retained in memory and qualities of the lost object become part of the personality” (Segal, 1996, p. 71).

So long as the child’s disappointments by the idealized parental imago are gradual and manageable, the child is able to internalize and metabolize the foreign selfobject and these internalizations assume the psychological functions previously performed by the idealized object, becoming ideals. However, in the face of massive or sudden disillusionment, transmuting internalization does not occur because the child is unable to

fractionate overwhelming loss. She swallows the selfobject whole and is unable to metabolize it. Eating disorder symptoms may indicate trauma of this sort that has curtailed transmuting internalization such that a patient resorts to either cyclically consuming and rejecting or entirely rejecting food as it is seen as a selfobject.

Barring any such trauma, narcissistic development culminates in the formation of ideals and ambitions (Siegel, 1996, Ch. 4). Deficits in or trauma to the empathic self-selfobject relationship lead to an impaired ability to regulate and maintain cohesion in the self and self-esteem. It becomes clear that "just as oxygen maintains the integrity of the physical self, so empathy bathes the psychological self in the nutriment that guarantees its survival" (Geist, 1989, p. 8). As in object relations theory, disturbance in the empathic self-selfobject relationship is the origin of disordered eating.

Kohut's theory is indispensible in the study of eating disorders as it clarifies and specifies the qualities of the parent-child relationship necessary for the healthy development of the self. Winnicott's (1971) concept of "good-enough mothering" refers to empathic responding and eventual self-object failure, whereas traumatic "early misattunement" can be further understood as a lack of empathic responding and understanding between parent and child, explaining why eating disordered patients generally suffer from a "paralyzing sense of ineffectiveness" and perceive a lack of agency in their lives (Bruch, 1973). These patients have not felt empathic understanding, thus have never been recognized as truly real or been given the support to internalize soothing tension-regulating and adaptive self-object functions (Siegel, 1996). They use food to serve the self-object functions they cannot serve for themselves.

At this point, clinical examples of anorexic and bulimic patients may be helpful in further clarifying these general theoretical foundations for psychoanalysis and provide infrastructure with which to examine the fundamental differences between the disorders.

Clinical Examples

Anorexia nervosa: Ramona. The story of Ramona, a patient Ferguson and Mendelsohn (2011) describe in detail, serves to illustrate and bring us closer to the realities and complexities of anorexia. Ramona is a budding writer with a history of anorexia who sought therapy in a mental health clinic for three months of work before her condition worsened and she underwent in-patient treatment for her disorder. Three years after her treatment, Ramona returned to analysis with Ferguson and Mendelsohn.

She describes a sad and anxious childhood characterized by an unpredictable and shifting home environment. Ramona felt caught between “warring and chaotic” parents who eventually divorced when she was 11 (Ferguson & Mendelsohn, 2011, p. 362). Ramona shouldered the responsibility of caring for her younger siblings and felt alienated from her “anxious, obsessive, and occasionally explosive” mother (Ferguson & Mendelsohn, 2011, p. 362). She hungered for her father’s attention, especially after he left home and got remarried. These unstable relationships caused Ramona to develop “an unwavering conviction that she was unwanted and unloved and that she needed to manage all of her needs in order not to upset her unstable mother or further alienate her already distant father” (Ferguson & Mendelsohn, 2011, p. 363).

Ramona’s first relationship with a boyfriend followed the same pattern as her interactive experiences with parents and others: anxiety and fear arose whenever feelings

of vulnerability or desire emerged. Ferguson and Mendelsohn (2011) explain, "whenever Ramona did not receive the reassurance or comfort from [her boyfriend] that she needed, feelings of piercing hurt, anger, and self-loathing followed" (p. 364). Upon injury, she would shut down, "become mute and withdrawn, expressing a hope that he would notice her cold demeanor while simultaneously denying and undoing her desire for consolation. Ramona would then retreat to the solitary activities of restriction, compulsive exercise, and self-injury in an effort to manage unbearable feeling and restore a sense of agency" (p. 364).

This is a commonly recognized pattern with anorectics: they have difficulty recognizing and responding to their own bodily states and inner emotions, suffering from a sense of ineffectiveness and lack of agency (Bruch, 1973, Ch. 14). Ramona's analyst says that she "had difficulty articulating her inner experience," instead providing concrete reports of her body and food rituals with little self-reflection (Ferguson & Mendelsohn, 2011, p. 362).

Bulimia nervosa: Jessica. In contrast to Ramona's lack of self-reflection, Krueger (1997) describes the case of a bulimic patient, Jessica, who clearly reflects on feelings she has in the process of a binge. Krueger finds:

> As we examined in detail a bulimic episode, [Jessica] described first being aware of a mixture of feeling empty and uncomfortable, sometimes depressed. She turned immediately to food, with a desire to numb the emptiness. During the binge itself, she felt pleasure, sometimes euphoria. She experienced a magical soothing and a sense that she could have, for a moment, whatever she wanted, entirely within her control. After the binge, she experienced a distended and

> painful stomach...Her dysphoria was now an entity that had form, shape, and remedy. She could actively and immediately rid herself of the problem by purging. Her purge was the actual release of discomfort with resulting physiological calm, as well as the imagined purging of the anger at not getting what she needed. By purging, she ridded herself symbolically of rage as well as physiologically regulating her immediate tension state. (p. 625)

The feeling of “impending or actual disconnectedness with an important other” or with her ideal self, both disruptions of the self-selfobject bond, Krueger concludes, always precipitates this binging and purging cycle (p. 625). These feelings are mirrored in Jessica’s childhood, when she “felt ineffective at getting her parents to respond to and validate her feelings, perceptions, value” (p. 627). Jessica describes feeling empty and lonely as a young girl, wishing that something bad would happen to her, “like an accident or bleeding,” so that people could see her pain and comfort her (p. 626). She attempts to elicit a specific response or validation from an important object, but never feels empathic recognition, so she must make her pain concrete. In the bulimic cycle, these feelings become the object itself, to be spit out or taken in. Thus the binge and purge have an immediate regulatory effect; they are calming and make Jessica feel in control.

Differentiating between Eating Disorders

Kadish (2012), in exploring the distinctive symptom manifestations of anorexia and bulimia, identifies a paradox between the commonalities shared by eating disorders (namely that as the result of a disruption in the early relationship with the caregiver, eating disorder symptoms stem from fantasies related to incorporation and expulsion originating from this early infant-mother relationship) and the diversity of the individual

personality organization (eating disordered patients have been diagnosed as neurotic, borderline, etc. yet the diagnosis makes little difference in the severity of the symptoms). In order to resolve this paradox, Kadish brings in Steiner's (1987) concept of the "third position," which acts as a borderline area between the paranoid-schizoid and depressive positions. The third position is activated by pathological organization, a hybridized personality structure resulting from an attempt to reconstitute the self in the aftermath of violent projective identification or disintegration. This position functions as a defense against fragmentation, confusion, and the mental pain and anxiety of the depressive position (Kadish, 2012; Steiner, 1987). Kadish asserts that in conditions provoking overwhelming anxiety, the psychic skeleton of a pathological organization is activated and makes the escape into psychic retreat possible.

Within this framework, eating disorder symptoms – binging and purging or severe restriction – function to bring about the third position. Kadish (2012) reports on three individual cases of different eating disorders, from an anorexic patient, a bulimic patient, and a binge-eating patient, and evaluates each patient's individual symptoms with regards to their pathological organizations. In all three cases, there was variation in the nature of the anxieties causing the activation of the pathological organization, which ultimately result in different disorders. Jenna's anorexia began as a result of anxiety of a depressive nature at the time of puberty, a time when true separation and individuation is called for. She describes feeling preoccupied with worry over whether the boy she likes will like her back, whether she will be able to manage her schoolwork, and if she will cope socially at the school dance. These concerns are very similar to those of Ramona, the anorexic patient of Ferguson and Mendelsohn (2011), whose disorder-provoking anxiety manifests

in an inability to handle feelings of vulnerability and desire in her relationship with her first boyfriend. In contrast, Sarah, Kadish's bulimic patient, suffers anxiety about her separation from and relations to her objects. She expresses guilt about having chosen to leave her husband to study overseas and fear of the dangers of separation. Jessica, the bulimic patient whose case was discussed previously (Krueger, 1997), shares similar anxieties, worrying about her connection to her important self-objects and her ideal self.

Notably, *both* anorexic and bulimic patients describe sadomasochistically structured pathological organizations taking effect. It appears that in eating disorders, pathological organization, which was initially the result of attempts to reconstitute the self and protect it from further injury, becomes malevolent and destructive. Donald Kalsched (1996) examines this phenomenon through the case of "Mary and the Food Daimon." Upon returning from a vacation, Kalsched finds his patient, Mary, looking "bloated, flushed, depressed," and ten bounds heavier after a period of binging (p. 31). Remarkably, Kalsched "became aware of disappointment – almost a feeling of betrayal" as if Mary had cheated on him (p. 31). Mary describes her binge as a possession by the Devil, a seductive entity who coaxes her to overeat and implores compliance. Kalsched calls Mary's inner diabolical, seductive figure a "Trickster" and "Daimon-lover" who demands submission to her body's cravings (p. 32). He asserts that these surrenders to the daimon fail to satisfy Mary's sense of emptiness, and that her "midnight trysts with the food devil were tantamount to repeated rapes and violations. In the sober light of morning she felt devastated, her hopes crushed, her diet broken, her relationship to therapy…threatened with guilt" (p. 32). The daimon acts as a sadomasochistic pathological organization (Kadish, 2012), seducing Mary into an altered fantasy state –

the psychic retreat – in order to prevent the fragile self from “being dismembered in a too-harsh reality” (Kalsched, 1996, p. 40). He serves as a “self-care system,” according to Kalsched.

Kadish notes the presence of this organization in both anorexic and bulimic cases. Sarah narrates her experience of a binge and purge cycle as if she is bartering and colluding with a sadistic part of herself, while Jenna describes the feeling that part of herself wants things while another part enjoys seeing herself not get what she wants. Based these reports, Kadish concludes that sadomasochistic pathological organizations are common to both anorexia and bulimia, but that the nature of the anxieties leading to the organizations differs, as does the use of the intermediate object to bring about psychic retreat. In an eating disorder such as anorexia nervosa, where starvation is a main feature of the illness, the avoidance of food is used as an intermediate object to activate a psychic structure that allows entry into a state of manic omnipotence and denial of reality. Jenna describes this psychic retreat as a “chemically induced coma” or “hibernation” (Kadish, 2012, p. 240). In an eating disorder where starvation is not a feature or is only one aspect of the illness, food is used as an intermediate object to escape painful feelings in the binge phase of the cycle, but escape into psychic retreat is short-lived and quickly followed by intensified feelings of shame, guilt, and anxiety.

Just as Kadish (2012) defines food as an intermediate object – something that replaces rather than represents the object – for the eating disordered individual, so Freedman and Lavender (2002) describe anorexia and bulimia in the context of desymbolization, a mode of concrete thinking in which “there is no ‘as-if’ attitude, no multiple meaning, and no opportunity for self-reflection” (p. 169). Eating disorder

symptoms, it would seem, inhabit the sphere of desymbolization – in the course of the disorder the body becomes a source of transmission for thoughts and feelings the mind cannot acknowledge or make meaning out of. Because eating disorders are the result of very early trauma, as in the case of Mary, anxieties got their start before a coherent ego was formed, thus when they resurface they cannot be psychically represented but must be "banished to the body or relegated to discreet psychical fragments between which amnesia barriers have been erected" (Kalsched, 1996, p. 34). Experience can only become meaningful when affects are "given mental representation by a transitional parental figure so that eventually they can reach verbal experience in language and be shared with another person" (Kalsched, 1996, p. 37). Thus, desymbolization contextualizes all eating disorders.

However, desymbolization is broken down into two motivational forces that "throttle meaning": evacuation, which is maintained through the defense of foreclosure, and disavowal, which is maintained through the defense of repudiation (Freedman & Lavender, 2002, p. 178). Anorexia, a syndrome of "no entry," is characterized by evacuation-foreclosure desymbolization. The anorectic feels beleaguered by "invasive, persecutory others," thus takes the defensive stance of "blocking access to any input experience that is potentially intrusive" (Freedman & Lavender, 2002, p. 184). In the case of Ramona, her feeling of being invaded could be seen to stem from her mother's explosiveness and Ramona's subsequent need to take the responsibility of caring for her siblings. Thus, in all of her interpersonal relationships, Ramona shuts down at the moment of injury.

Bulimia, on the other hand, is not a syndrome of no entry but rather the presence of a "hollow, hungry, angry self" and is thereby characterized by a cycle of disavowal (Freedman & Lavender, 2002, p. 185). The first phase of the cycle, the binge, is pure desymbolization. The bulimic devours inordinate amounts of food as if possessed, and "the entire focus of attention is to take in everything she sees; there are no other thoughts. It is a state devoid of an even minimal notation system" (p. 185). No meaning is allowed to enter. The second phase is repudiation in the form of purging. Notably, the bulimic's "efforts to rid herself of the disgusting inner content are prolonged and frantic," revealing her disgust over not only having eaten the food, but also of having to capitulate to that desire (Freedman & Lavender, 2002, p. 186).

Furthermore, Freedman and Lavender assign quantitative factors to each mode of desymbolization, claiming that "psychic equivalence occurs in both modes, but when it is pervasive we are likely dealing with evacuation, whereas when it is segmental, disavowal seems to be present" (p. 178). On the surface, segmental desymbolizers appear to have rich inner lives, but closer examination reveals a "core of frozenness that cannot be penetrated, a belief system immune to interpretation" (p. 178). As a disavowal cycle, bulimia is quantified as segmental psychic equivalence. The bulimic has the "capacity to register and tolerate momentary dreaded thoughts, then to repudiate them" (p. 179). Unlike the anorectic, who Freedman and Lavender have found to be completely shut off, the bulimic is capable of experiencing waves of emotions, but can barely articulate them. In contrast, for pervasive desymbolizers, the concretized sense of stuckness is all-absorbing. Anorexia as it is conceptualized as evacuation-foreclosure is also quantified as pervasive psychic equivalence, characterized by concreteness and barren affect.

Concurrently, Ferguson and Mendelsohn (2011) describe Ramona as incapable of articulating her experience, instead describing the concrete methods by which she manages her affect.

By bringing Kadish's (2012) theory of pathological organization together with Freedman and Lavender's (2002) theory of desymbolization, we can begin to see where eating disorders diverge, from a psychoanalytic perspective. Kadish understands all eating disorders as sadomasochistic pathological organizations, but acknowledges a difference between anorexia and bulimia in both the nature and length of the psychic retreat made available by the pathological organization, as well as a difference in the way that food functions as an intermediate object in this process. Freedman and Lavender's theory clarifies just how the anorectic's use of intermediate objects differs from that of the bulimic. Intermediate objects, as defined by Kadish (2002), are psychically condensed such that they stand concretely in place of the object, thus can be understood as desymbolization. The anorectic's self-starvation functions as evacuation-foreclosure desymbolization, whereas the bulimic's binge and purge functions as disavowal-repudiation desymbolization. The anorectic's disavowal is sustained, keeping her in a psychic retreat, but the bulimic's segmental desymbolization allows only short-lived escape to psychic retreat in the face of overwhelming anxiety. According to Kadish (2012), yet another difference between the two disorders is the conditions of anxiety that bring on psychic retreat. The anorectic feels intense anxiety when selfobject relationships provoke feelings of vulnerability or desire, whereas the bulimic's anxiety stems from fear of separation from selfobjects.

The differences between anorexia and bulimia, identified as the instigating anxieties, the nature of the psychic retreat, and the use of food as an intermediate object, may insinuate some more profound yet nuanced difference between the disorders, stemming from the causative trauma. After a number of years assessing, treating, and supervising patients suffering from eating disorders, Williams (1997) asserts eating disorders commonly result from a failure in the container/contained relationship originally theorized by Bion in 1962, in which the object serves a vital developmental function for the child by “receiving the projections and feeling the discomforts a child himself cannot give a name to or think about.” (p. 938). The containing object, which could be thought of as a selfobject serving psychological functions, receives the child’s projections and attempts to give them a name, modify them, and make them thinkable. In the case of an eating disordered patient, Williams (1997) stresses, this container/contained relationship is reversed and the child is “used, almost always unconsciously, by one or both of his parents as a vehicle as a *receptacle* of their projection, *their* own unmetabolized feelings or ‘ghosts’” (p. 938). What results are two patterns of behavior: first, “a defensive rejection of input not confined to food intake, but extending at times so widely that it might be referred to as a ‘no entry system of defences”, characteristic of the anorectic, and second a “psychically porous” and open system which is more common in the bulimic (Williams, 1997, p. 927).

Williams’ (1997) distinction, when framed in the context of other theories differentiating anorexia and bulimia, suggests that individuals suffering the two disorders may suffer the same traumatic failure in the caretaker-child relationship, namely a failure of the container/contained dynamic, but they frame and cope with this trauma differently.

Possibly the anorectic feels that she was used as a container in her earliest object relationships, asked to hold and respond to the anxieties of the object that her fragile self was not yet capable of managing, and as a result must completely close herself off to avoid being overwhelmed by her own desires and vulnerabilities. She needs nothing so that her neediness will not ruin her imperative relationships. The bulimic seems to have a different sense of herself, as an empty and hollow wasteland, contaminated by another's projections, and must repeatedly take in and regurgitate the anger she feels at never being able to be completely "full of herself" (Ferguson & Mendelsohn, 2011). Her cyclical symptomatology can be seen as an attempt to cleanse herself of foreign bodies.

Nevertheless, whether or not the true differences between the disorders stem from perceptions of the earliest traumatic relationships, their distinctive symptom manifestations require different approaches in treatment.

Psychoanalytic Treatment of Anorexia and Bulimia

Bruch (1973), one of the first to deal with the theory of psychoanalytic treatment of eating disorders in general, studied anorexia and obesity. She warned against dealing directly with the patient's disordered eating behaviors, asserting that therapy should "attempt to repair the underlying sense of incompetence, conceptual defects and distortions, isolation and dissatisfaction" which she saw as common features of all eating disorders (p. 335). Eating disordered patients suffer from an inability to respond appropriately to their own needs and a sense of ineffectiveness, making them vulnerable to the influence of others. Bruch therefore believes that an interpretive approach, where the patient reveals her secrets and the analyst attempts to make meaning out of these experiences, is nothing more than a painful repetition of the dysfunctional interaction

between patient and parent, where patient feels the need to forfeit her own meanings in favor of the primary caregiver's. Ultimately, Bruch asserts that the most effective therapeutic approach is to finally make a patient feel listened to, to hold her experiences in a safe space where she can explore and reinterpret them herself.

From a self-psychological viewpoint, the therapist should assume an attitude of sustained empathic enquiry in order to help the eating disordered patient establish an attitude of interest in and feeling of acceptance of her own emotional life. By helping the patient recognize her emotions as internal signals that are limited in duration, the therapist can foster growth in the patient's capacity to tolerate emotional experience. Eventually, the patient will come to experience herself with "a sense of vitality, authenticity, and agency" (deGroot & Rodin, 1994, p. 311). She can own herself, instead of feeling invaded or abandoned.

However, when the differences between anorexia and bulimia are assessed, they begin to complicate the treatment picture. Freedman and Lavender (2002) assert that the disorders' different organizing fantasies – the stance of no entry, represented by evacuation and foreclosure, or the stance of gorging and disowning, represented by disavowal and repudiation – take up residence in the therapist's mind. The evacuated anorectic obliterates the therapist, and "the receiving other is not only confronted with a sense of helpless, but also the sense of feeling psychically starved and bereft of any basis of valid identification" (Freedman & Lavender, 2002, p. 191). Of anorexic patients, Williams (1997) says, "I have often noticed in my countertransference that 'no entry' patients can break and enter into me with powerful projections of an intensity that parallels their dread of being invaded" (p. 928). This is not true of the bulimic, who does

not project as heavily or frequently as “no entry” patients. Instead, the hungry, hollow bulimic evokes “states of intense connectedness consumed and then disowned” (Freedman & Lavender, 2002, p. 191). Williams (1997) explains that “the message one receives in the countertransference when working with ‘porous’ patients…is: ‘Please help me to tidy up. Please help me to differentiate foreign bodies from what is nourishing and to internalize a filing system, an organizing function of my own’” (p. 938). For Freedman and Lavender, this presents a problem of reception: whereas the pendulum of the bulimic’s disavowal cycle “suggests a thrust toward a therapeutic interchange,” the anorectic’s commitment to needing nothing and her likelihood to “loathe anything that threatens to be injected into herself” poses a problem for the creation of a therapeutic space (p. 192). They conclude by suggesting that the different aspects of desymbolization each have a “certain intuitive tilt leading to a preferred therapeutic stance” (p. 194). These signifiers stress that “what masquerades as an eating disorder is also a meaning disorder,” and the recognition of the method of desymbolization should facilitate the symbolization of the frozen constellation (p. 194). Neither disorder need be considered a hopeless case.

Returning to the idea of an eating disordered patient as a receptacle for the unmetabolized experiences of the parent, Williams (1997) defends the following:

> The internal landscape of a child may show craters where the foreign bodies have landed, but around these craters there may be a desolate volcanic terrain or a devastated bombsite, of there might be at times, as in my patient Daniel, soil that has been able to nourish growth, in spite of craters. There might be some live and

> enlivening internal objects that inhabit the internal landscape and mitigate the inimical nature of the foreign bodies. (p. 939)

Treatment of the eating disordered patient requires one to sort through the rubble left behind by earlier, traumatic relationships and find those tendrils of life and hope from which growth may be possible.

Conclusion

Considering the differences between anorexia and bulimia, in symptom manifestation, causation, and treatment, provides a more complete understanding of the eating disordered patient in her psychic structure and relationship with reality, the external world, and others. Self-psychology and object relations theory have explained how an initial trauma of a certain nature might alter an individual's relationship to such a life giving, nourishing substance as food such that it ceases to hold that meaning. However, after detailing the distinctions between the disorders with regards to initial trauma, pathological organization, psychic retreat, use of food as an intermediate object, capacity for symbolization, and best approach to treatment, I am left feeling slightly unsatisfied. The question that originally spawned this psychoanalytic inquiry – why am I bulimic rather than anorexic? – still lingers. My complete inability to starve myself despite an unyielding yearning to be waif-like and skeletal, my at times uncontrollable compulsion to binge and purge, has left me with the sense that there is something fundamentally different about my experience of trauma and ability to cope with it as compared to the anorectic's. However, based on the work of Williams (1997) and others, little difference has been documented in the causative trauma for the bulimic versus anorectic patient. Much of the psychoanalytic theory around eating disorders sees

anorexia and bulimia stemming from a very similar trauma at the same point in development. Why does one person remain “porous” and the other take a “no entry” stance when faced with the same failure of the container/contained relationship? Perhaps it is something inherent in the personality that predisposes an individual to anorexia or bulimia, or perhaps it is buried in the nature of the trauma so subtly that it has not been identified, but the gap in the theory in this dominion of psychoanalytic understanding is apparent nonetheless. Answers to this query might further solidify our capability to treat these disorders, opening up the therapeutic space in places where all hope seems lost.

On my own part, through this examination that began as a personal inquiry, I have come to understand that what I desire above all else is not to be evacuated, frozen, and closed off in a desperate attempt to preserve my being at the expense of all else. I believe my envy of the anorectic to be representative of my own psychic structure in two parts: first, it exemplifies a wish to need nothing and want nothing so that I am never forced to impose my neediness on others, making me feel out of control and guilty, and second it serves as an emblem of my drive for perfection, because in my eyes the skeletal anorectic has perhaps achieved an ideal of beauty that I can never reach. Maybe what I have done here is seize on the healthiest, most hopeful parts of my psyche that the anorexic patient is often found to lack; the cyclical nature of my symptoms suggests a thrust towards health, an ability to take in and digest, to recognize my sickness and want to be well. Devouring my disorder in all the various forms that look appetizing to me and then regurgitating it in a configuration that I can revise and alter has begun to restore my sense of agency. The symptomatology of bulimia has been transformed and sublimated into a more manageable, healthy pursuit of perfection.

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